Pennine Lancashire Palliative and End of Life Care Model

Pennine Lancashire
Palliative and End of Life Care

Overarching Principles

Supporting the people in Pennine Lancashire to live well before dying with peace and dignity in the place of their choice

End of Life Care

"End of Life Care is care that helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patients and family to be identified and met throughput the last phases of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support."

National Council for Palliative Care (NCPC)

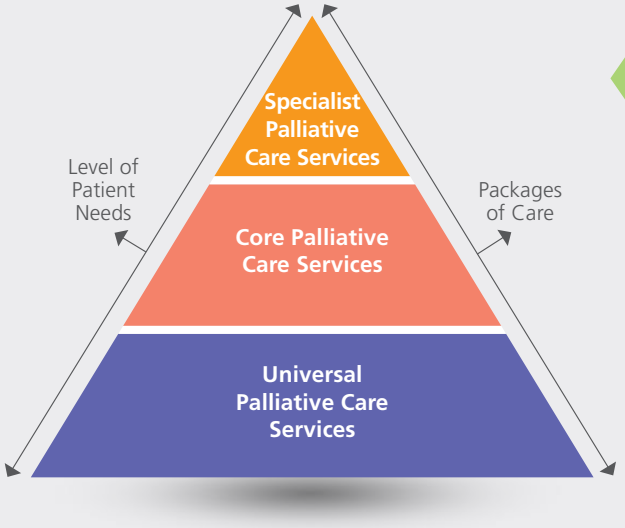
It should include:

- A person centered approach to care – including the person and those closest to them in all aspect of their care including the decision making process around treatment and care as they want
- Open, honest and sensitive communication with patient and those important to them
- Care which is coordinated and delivered with kindness and compassion
- All discussions and decisions to follow the principals of the Mental Capacity Act (MCA 2005)

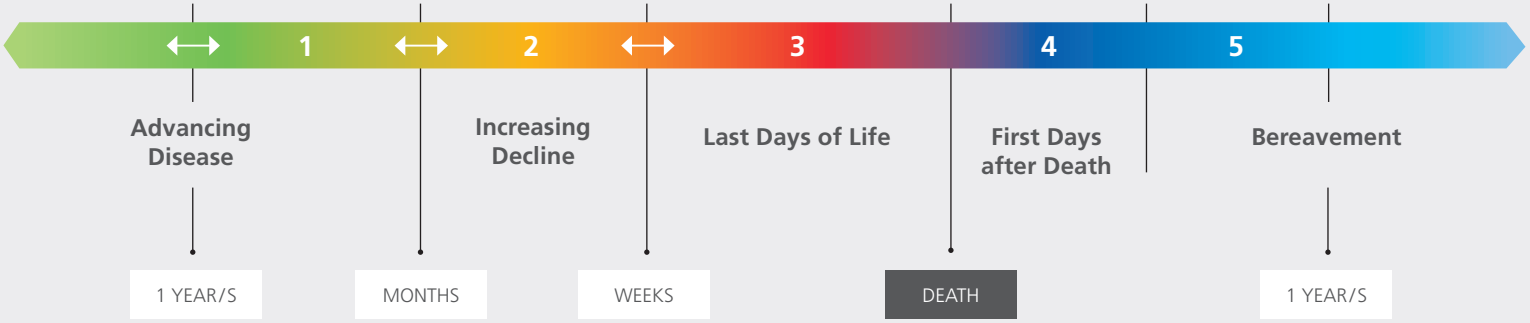
Adapted from 'The North West End of Life Care Model – End of Life Care Good Practice Guide', Greater Manchester, Lancashire and South Cumbria Strategic Clinical Network, May 2015

The 'Elements of Dedicated Palliative Care' model applies throughout the stages of the 'North West End of Life Care' Model

Elements of Dedicated Palliative Care



The North West End of Life Care Model



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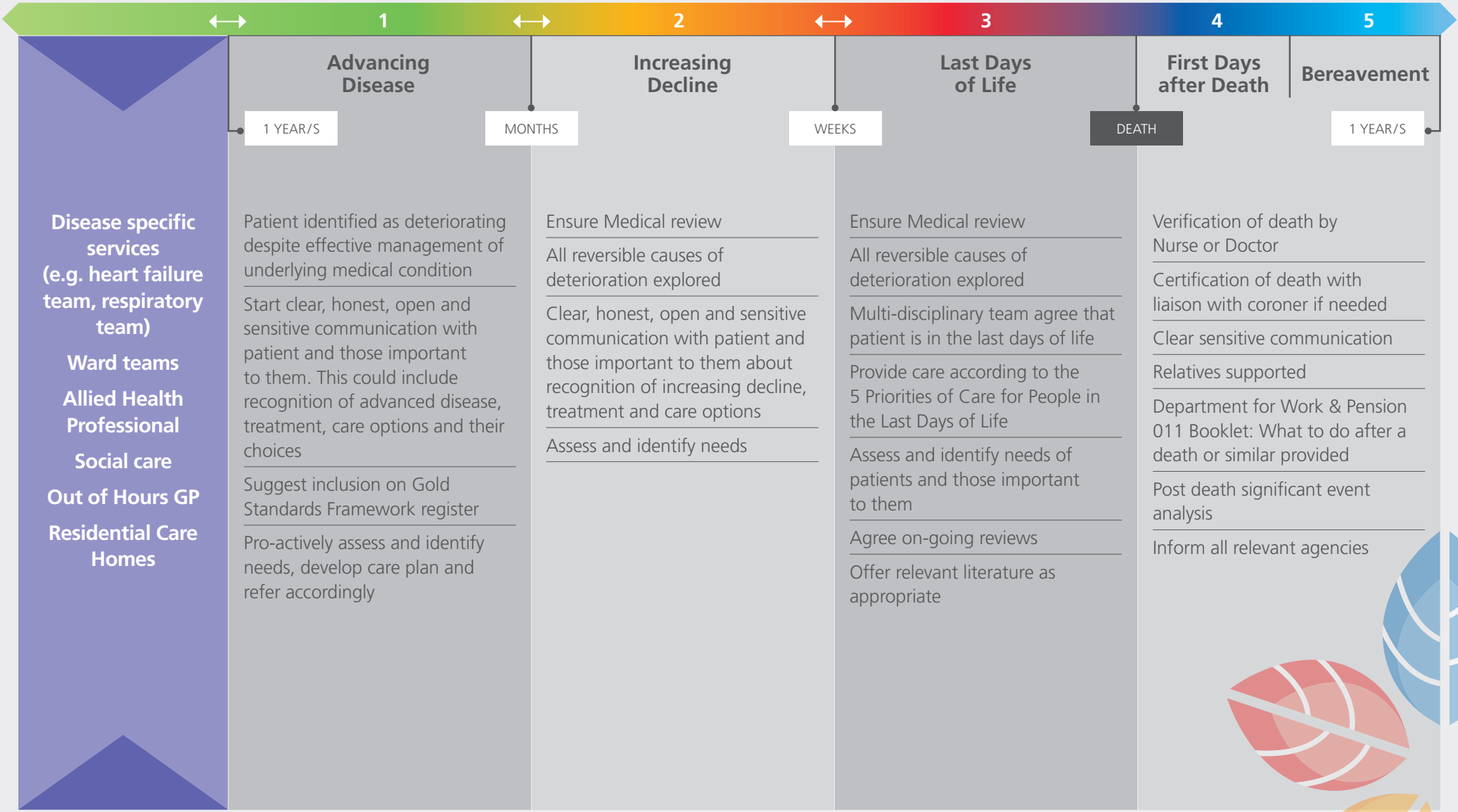
1
2
3
4
5
Advancing Disease
Increasing Decline
Last Days of Life
First Days after Death
Bereavement
1 YEAR/S
MONTHS
WEEKS
DEATH
1 YEAR/S
Universal Palliative Care Services
Disease specific services (e.g. heart failure team, respiratory team)
Ward teams
Allied Health Professional
Social care
Out of Hours GP
Residential Care Homes
Patient identified as deteriorating despite effective management of underlying medical condition
Start clear, honest, open and sensitive communication with patient and those important to them. This could include recognition of advanced disease, treatment, care options and their choices
Suggest inclusion on Gold Standards Framework register
Pro-actively assess and identify needs, develop care plan and refer accordingly
Ensure Medical review
All reversible causes of deterioration explored
Clear, honest, open and sensitive communication with patient and those important to them about recognition of increasing decline, treatment and care options
Assess and identify needs
Ensure Medical review
All reversible causes of deterioration explored
Multi-disciplinary team agree that patient is in the last days of life
Provide care according to the 5 Priorities of Care for People in the Last Days of Life
Assess and identify needs of patients and those important to them
Agree on-going reviews
Offer relevant literature as appropriate
Verification of death by Nurse or Doctor
Certification of death with liaison with coroner if needed
Clear sensitive communication
Relatives supported
Department for Work & Pension 011 Booklet: What to do after a death or similar provided
Post death significant event analysis
Inform all relevant agencies

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	1	2	3	4	5
	Advancing Disease	**Increasing Decline**	**Last Days of Life**	**First Days after Death**	**Bereavement**
	1 YEAR/S	MONTHS	WEEKS	DEATH	1 YEAR/S
Core Palliative Care Services	***First two points above plus:***	***As above plus:***	***As above plus:***	***As above plus:***	
District Nurses	Key worker identified	On-going communication with key worker	On-going support from key worker	Liaison between services to agree who will provide bereavement follow up contact	
GPs	Holistic needs assessment of patient and development of care plan for identified needs	Regular assessments and care plan adjusted according to changing needs	Daily reviews by District Nurses or ward nurses	Follow up bereavement contact 2-4 weeks after bereavement and sign post to bereavement counselling services as needed	
Community Hospitals	Include patient on Gold Standards Framework register and review their care regularly	Regular discussion at Gold Standard Framework meetings	Care planned and delivered according to the 5 Priorities of Care for People in the Last Days of Life	Staff supported	
Nursing Homes	Carer's assessment – needs of those identified as important are explored, respected and met as far as possible	Pro-active carer's assessment	Anticipatory medication prescribed and available	Offer dedicated access to bereavement support services	
Some disease specific Community Nurse Specialists (depending on specialty)	Agree on-going monitoring and support to avert crises	Regular District Nurse support and more frequent reviews	Carer's assessment	Refer to Dedicated Bereavement Service if needed	
Allied Health Professionals	Identify when there is an opportunity to offer Advance Care Plan discussions/Preferred Priorities of Care/Do not attempt cardiopulmonary resuscitation/ Deactivation of Implanted Cardioverter Defibrillator etc	Advance Care Plan discussions offered and reviewed	Advance Care Planning discussions offered and reviewed		
Hospice at Home	Referral to other services as indicated by identified needs such as Allied Health Professional, Speech & Language Therapy, Social Services, Specialist Palliative Care	Do not attempt cardiopulmonary resuscitation and Implanted Cardioverter Defibrillator deactivation considered and outcome documented	Rapid discharge for the dying patient if preferred place of death is at home (discharge within 24 hours)		
Hospice Day Therapy including Complementary Therapy and Physiotherapy	Request consent to share information and create Electronic Palliative Care Coordination System record	Referral to other services as indicated by identified need	Review package of care and equipment and offer additional support		
Integrated Care Services	Update Out of Hours/North West Ambulance Service	Consider anticipatory medication for the dying patient	Update Electronic Palliative Care Coordination System and Out of Hours/ North West Ambulance Service		
Spiritual Support Services		Consider Continuing Health Care funding, DS 1500	Do not attempt cardiopulmonary resuscitation, Implanted Cardioverter Defibrillator discussion and deactivation if not previously initiated		
Bereavement Support Services		Update information on Electronic Palliative Care Coordination System, record	Referral to other services as indicated by identified need		
		Update Out of Hours/ North West Ambulance Service			

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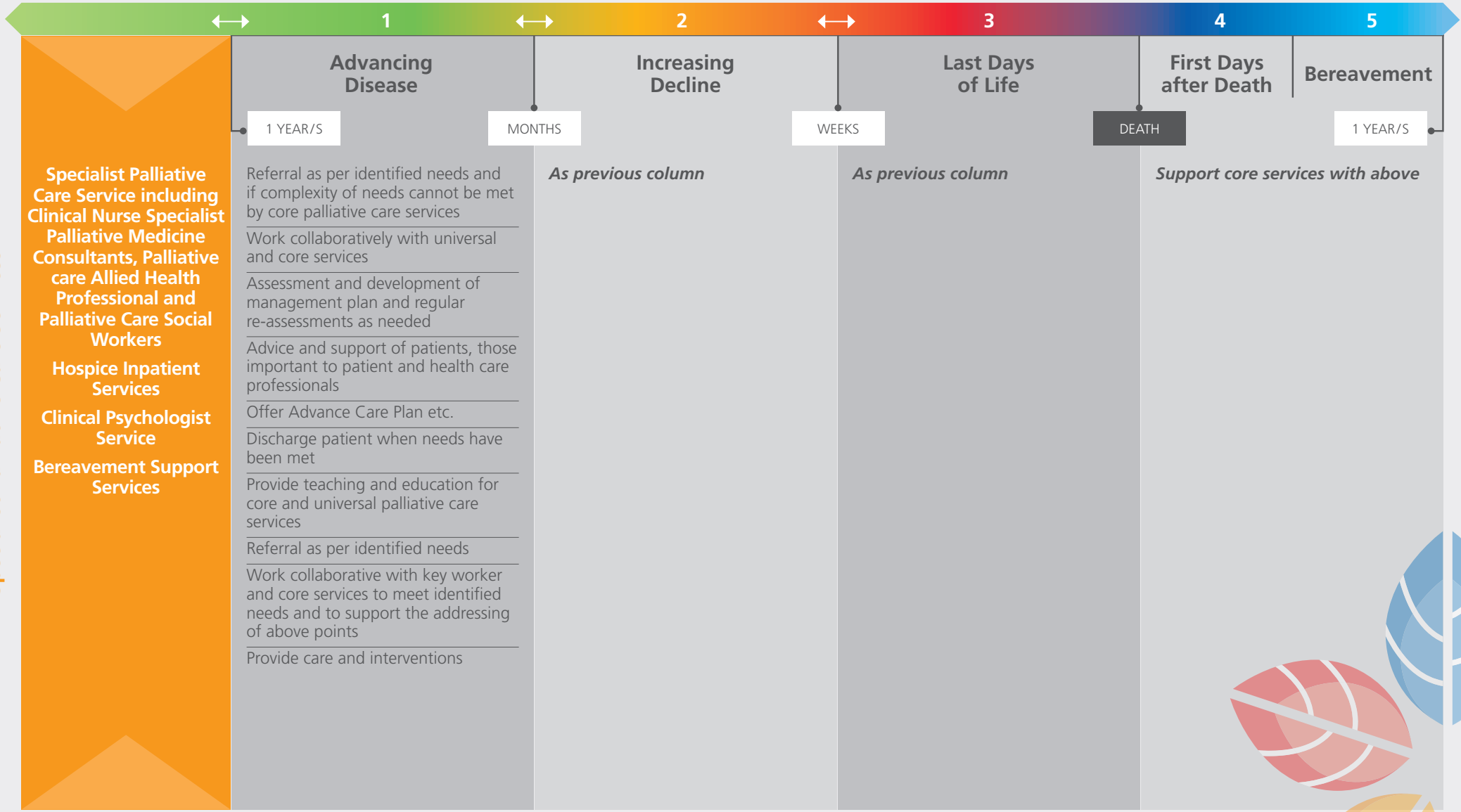
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Advancing Disease
Increasing Decline
Last Days of Life
First Days after Death
Bereavement
1 YEAR/S
MONTHS
WEEKS
DEATH
1 YEAR/S
Specialist Palliative Care Services
Specialist Palliative Care Service including Clinical Nurse Specialist Palliative Medicine Consultants, Palliative care Allied Health Professional and Palliative Care Social Workers
Hospice Inpatient Services
Clinical Psychologist Service
Bereavement Support Services
Referral as per identified needs and if complexity of needs cannot be met by core palliative care services
Work collaboratively with universal and core services
Assessment and development of management plan and regular re-assessments as needed
Advice and support of patients, those important to patient and health care professionals
Offer Advance Care Plan etc.
Discharge patient when needs have been met
Provide teaching and education for core and universal palliative care services
Referral as per identified needs
Work collaborative with key worker and core services to meet identified needs and to support the addressing of above points
Provide care and interventions
As previous column
As previous column
Support core services with above

It is important to recognise that response time is critical to the success of this model. It is intended that expected response times will be reviewed separately.